DEPARTMENT OF THE ARMY
HEADQUARTERS, WALTER REED ARMY MEDICAL CENTER
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WRAMC Regulation
No. 40-3

19 April 2002

Medical Services

WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT (WLS), INCLUDING DO NOT RESUSCITATE (DNR) ORDERS

1. History

This regulation supersedes WRAMC Regulation 40-3, 1 January 1999.

2. Applicability

This policy applies to all clinical staff members assigned or attached to WRAMC.

3. Purpose

This regulation establishes the policy and procedure for the initiation of orders to suspend resuscitation from a cardio-respiratory arrest and for executing decisions to withhold or withdraw life-sustaining treatment.

4. References

a. Army Regulation 40-3, Medical Dental and Veterinary Care, 28 January 2002.

b. Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying: A Report by The Hastings Center, Indiana University Press; 1987.

c. Joint Commission on Accreditation for Healthcare Organizations (JCAHO) Accreditation Manual for Hospitals (Current Edition).

d. Patient Self-Determination Act of 1990 (PL 101-508).

e. WRAMC Reg 40-8, Medical Services: Implementation of Advance Directives, 18 April 2002.

f. WRAMC Reg 40-92, Medical Services: Patient Care Committees, Boards and Councils, 1 September 1999.

g. WRAMC Reg 40-93, Withdrawal of Health Care Professional from Patient Care Due to Ethical or Religious Beliefs, 18 April 2002.

5. Explanation of abbreviations and terms

a. Center Judge Advocate (CJA).

b. Decision-Making Capacity (DMC).

c. Do Not Resuscitate (DNR).

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*This regulation supersedes WRAMC Regulation 40-3, 1 JAN 99.

d. Ethics Consultation Service (ECS).

e. Graduate Medical Education (GME).

f. Hospital Ethics Committee (HEC).

g. Withdrawing or Withholding Life Sustaining Treatment (WLS).

h. Walter Reed Army Medical Center. (WRAMC).

6. Definitions

a. Advance Directive. A written document defining a patient's wishes, should (s)he become incapable of participating in medical decisions. These include a "Durable Power of Attorney for Health Care" and a "Living Will".

b. Attending Physician. The physician with clinical privileges who is ultimately responsible for the care of a patient.

c. Decision Making Capacity.

(1) The following individuals shall be presumed capable of making health care decisions, including the decision to forgo life-sustaining treatment, unless certified otherwise under paragraph d.(1) below:

(a) Any patient who has reached the age of 18 years.

(b) Any patient less than 18, who is on active duty status or an emancipated minor or mature minor as determined by local law.

(2). Incapacitation. A medical term to designate a patient's inability to participate and/or be involved in a decision making process generally as result of a severe medical and/or psychiatric illness (e.g. coma, dementia). A person who is incapable of understanding health care choices, or making a decision concerning particular treatments at issue (i.e. understanding the relevant risks, benefits, and alternatives to therapy - including no therapy), or communicating a decision, even if capable of making it, may be certified as incapacitated to make health care decisions.

d. Procedure for determining incapacitation.

(1) Mental incapacity to make a health care decision shall be certified by the attending physician and a second physician, one of whom shall have examined the patient within 2 hours before making the certification. The certification shall be based on a personal examination of the patient. If a patient is unconscious, or unable to communicate by any means, the certification of a second physician is not required.

(2) The certification and clinical basis for incapacity will be accurately recorded in the physician's note.

(3) Minors less than 14 years of age are categorically considered incapacitated to make health care decisions.

(4) If there is a question regarding a patient's participation in decision-making, or if there is

disagreement among members of the medical care team, or if determination of legal incapacitation is needed consultation should be sought with psychiatry. Consultation with the HEC should also be considered.

(5) For those active duty patients who require an expeditious adjudication of the medical board and are found to be incapacitated, a psychiatrist must make that determination and be a member of the medical board.

e. DNR Order. A written order to suspend the otherwise automatic initiation of resuscitation. A DNR order does not imply the withholding or withdrawal of any other therapy.

f. Life-Sustaining or Life-Prolonging Treatment. Life-sustaining treatment is any medical procedure or intervention that supports life. Intravenous fluid therapies, parenteral nutrition, and enteral nutrition are examples of life-sustaining medical interventions. Medical interventions necessary to alleviate pain are not considered life-sustaining treatment.

g. Persistent or Permanent Vegetative State. A chronic state of diminished consciousness resulting from severe generalized brain injury from which there is no reasonable possibility of improvement to a cognitive state.

h. Physician with Clinical Privileges. A physician (the attending) whose application for clinical privileges was reviewed by the Credentials Committee, and who has been granted clinical privileges by the Commander. Fellows with sufficient training and credentials may also be granted clinical privileges in their previously credentialed specialty. Interns and residents do not have clinical privileges.

i. Resuscitation. Refers to any means used to restore ventilatory and or circulatory function until spontaneously resumed or until artificial means are established or until the patient is pronounced dead. This includes both basic and advanced cardiac life support measures as recommended by the American Heart Association.

j. Surrogate Decision Maker. An individual empowered to make health care decisions on behalf of a patient who becomes incapable (see paragraph c. (2) above) of making or communicating a choice regarding a particular health care decision. This is sometimes referred to as "attorney in fact", "medical proxy", or "substitute decision maker".

k. Terminal Condition. An incurable condition resulting from injury or disease in which imminent death is predictable with reasonable medical certainty.

l. Withhold or withdraw order. A written order not to initiate or to discontinue (a) specific therapeutic modality(ies), including life-sustaining modalities.

m. Best Interest Standard. An assessment of what is good for a patient, typically the incompetent patient/child/infant, in a particular clinical situation which respects the patient's dignity and worth as a person but which does not rely on the patient's own concept of his/her good. In the case of children, parents are presumed to have an important (but not necessarily sole) role in determining their child's best interest.

n. Substituted Judgment. Making medical decisions for an incapable patient as if one were the patient

him/herself based on knowledge of that person's lifestyle and values of previously communicated wishes.

7. Policies

a. An order to resuscitate is a standing order, and resuscitation will be initiated unless there is a written DNR order to the contrary.

b. Life-sustaining treatment will be provided unless there is a written WLS order.

c. The decision to write a DNR and/or a WLS order is reached by concurrence of the attending physician with the capacitated patient or the surrogate decision maker of an incapacitated patient and must be fully and accurately documented.

d. Only a physician with WRAMC clinical privileges may write a WLS order. Any physician may record a verbal WLS order from the attending physician.

e. Nurses are not authorized to accept verbal WLS orders, to include DNR orders.

f. A patient with decision-making capacity has the legal and ethical right to refuse medical treatment at any time, even when it is considered life saving or life-sustaining. This decision may be stated verbally or through a written instrument, such as a living will or durable power of attorney for health care. The attending physician is responsible for providing a patient with a clear and concise explanation of his or her condition, any proposed treatments, the potential drawbacks of the proposed treatment or procedures, problems related to recuperation following the treatment, and the likelihood of success of the treatment. This includes resuscitation. The physician should clearly state that the patient will not be abandoned if a particular treatment is withdrawn or withheld, that comfort and pain management will continue to be provided, and that the patient's wishes will be respected, if at all possible.

g. A patient or the surrogate decision-maker may at times request limitation of resuscitation therapies (e.g. no endotracheal intubation or no pacemaker). These requests should be honored to the fullest extent medically possible (e.g., patient desires no chest compressions but suffers a cardiac arrest, it would be medically inappropriate to intubate and ventilate without cardiac compression).

h. A patient with decision making capacity who requests a DNR order or a WLS order has the right and discretion to determine when and if any family members or the surrogate decision maker should be notified of the decision.

i. Any WLS order will specify the treatment to be withdrawn or withheld. Such an order does not imply the withdrawing or withholding of any other treatment.

j. The ordering physician will ensure others responsible for the patient's care, particularly the nursing staff, are promptly notified of a WLS. All who are responsible for the patient's care should ensure they clearly understand the order, its rationale, and its implications.

k. DNR Orders in the Operating Room: Whenever a patient undergoes anesthesia and operative procedure(s) where there is a risk of cardiac and/or pulmonary arrest, the question of continuing or suspending the DNR order arises. A patient with a DNR order or the patient's surrogate decision-maker may decide to continue or to suspend the DNR order during the perioperative period (operation, procedure and relevant recovery time). Deciding whether to continue or suspend the DNR order is especially complicated by the nature of anesthesia, which in providing the benefits of amnesia and

analgesia may also result in cardiac and/or pulmonary arrest.

(1) The physician(s) (e.g., surgeon, anesthesiologist, primary care physician) shall discuss the DNR order with the patient or the surrogate decision-maker to determine whether to continue or suspend it during the perioperative period. It is strongly recommended that this discussion include the primary care physician.

(2) Relevant aspects of this discussion must be documented in the patient's chart.

(3) If the patient or the surrogate decision-maker elects to have the DNR order suspended during the perioperative period, this must be noted on the Physician's orders as well as the date and time (or conditions) when the DNR order is to be reinstituted.

(4) If the patient or surrogate decision-maker elects to have the DNR order remain in effect, and a member of the perioperative team is unable to carry out the patient's request, then the affected team member may transfer responsibility for the care of the patient to a health care professional able to carry out the patient's request.

8. Procedure for WLS

a. If the patient has an advance directive, its meaning and applicability for that admission will be discussed by the attending physician with the patient and whenever possible the patient's surrogate decision-maker, in order to have a clear understanding of the patient's wishes. This discussion between the patient, the attending physician, and the patient's surrogate decision-maker will be recorded in the progress notes of the patient's record as soon as possible.

b. If the patient with an advance directive lacks decision making capacity at the time of hospital admission the attending physician will discuss the directive with the patient's surrogate decision maker to clarify the advance directive as it relates to that admission.

c. Decisions for patients with decision-making capacity.

(1) When a patient understands the implication and consequences of the diagnosis and prognosis, the decision to forego life-sustaining treatment should be reached by the patient with the attending physician.

(2) A patient who has requested WLS may change his or her mind at any time. Medical personnel will proceed in accord with the patient's wishes and make appropriate entries in the medical record and notify members of the patient's health care team.

(3) The patient may request that family members not be involved in or informed of his or her decision. That request for confidentiality will be honored and documented in the medical record. This documentation will be made by a person who is not a member of the treatment team (this does not require a staff physician).

d. Decisions for incapacitated patients with "living wills".

(1) Any person 18 years of age or older may execute a declaration directing WLS should they be in a terminal condition or permanent vegetative state. The WLS order may be entered in the medical record according to the provisions of the “living will” or similar advance directive.

(2) When a surrogate decision maker differs or disagrees with the provisions of an advance directive executed by a now incapacitated patient, the matter will be referred to the HEC for prompt resolution in consultation with the Office of the CJA.

e. Decisions for incapacitated patients without advance directives:

(1) The surrogate decision-maker may authorize the withdrawal or withholding of life-sustaining therapy.

(2) If there is a question about who is the proper surrogate decision-maker or about WLS orders in the absence of a qualified surrogate decision-maker, the matter should promptly be referred to the ECS and the Office of the CJA. If there is doubt that the directions of the surrogate decision-maker are what the patient would have wanted or, lacking that information, that they are in the best interest of the patient, the matter should be referred to the HEC for prompt resolution.

(3) If after adequate assessment there is agreement by the Attending Physician and the patient's surrogate decision maker to withdraw or withhold life-sustaining treatment, a WLS order will be entered into the patient’s medical record.

(4) In any case where there is a disagreement concerning the withholding or withdrawal of life-sustaining treatment, the treatment involved will be continued while the matter is referred to the HEC to aid a prompt resolution.

(5) The surrogate decision-maker has the authority to grant, refuse, or withdraw consent to the provision of any health care service, treatment, or procedure based on the patient’s preferences. If the patient’s preferences are not known, the surrogate decision-maker bases said decision on the patient’s best interests. Additionally, the surrogate decision-maker has the right to review the health care records of the patient, the right to be provided with all information necessary to make informed health care decisions, the authority to select and discharge health care professionals to the extent the patient could, and the authority to make decisions regarding admission to or discharge from WRAMC.

(6) The surrogate decision-maker shall have priority over any other person to act for the patient in all matters regarding health care.

(7) The following persons in order of priority listed may act as surrogate decision- maker for any patient determined to be incapable of making health care decisions:

(a) Court appointed guardian or conservator of the patient.

(b) Spouse of the patient.

(c) Adult child of the patient.

(d) Parent of the patient.

(e) Adult sibling of the patient.

(f) The nearest living relative of the patient.

(8) If no individual in a prior class listed is reasonably available, mentally capable, and willing to act,
responsibility for decision making shall rest with the next reasonably available, mentally capable, and willing person on the list. If no individual listed above is available, the attending physician will contact the Office of the CJA and request an Ethics Consultation

(9) If there is a person who has more knowledge of the patient's preferences than any other person
listed in para. 8. e. (7) above (i.e., is best able to make "substituted judgment" on behalf of the patient), the Attending physician will request an ethics consult and contact the WRAMC CJA to determine that person's standing as a surrogate decision maker.

f. Documentation of a WLS order.

(1) A WLS order will be entered by a physician with WRAMC clinical privileges in the Orders of the inpatient treatment record, timed, dated and signed.

(2) Documentation in the Progress Notes will include.

(a) A description of the patient's medical condition corroborating the prognosis, including reference to any consultations relevant to the WLS decision.

(b) A summary of discussions with the patient, and/or the patient's surrogate decision-maker concerning the medical prognosis and the WLS.

(c) The decision making capacity status of the patient and the basis for a finding of the lack of decision making capacity.

(d) The authority upon which the final decision is based (e.g., capacitated patient's informed consent, surrogate decision-maker, court, etc.).

(e) In no instance will the patient or surrogate decision maker be asked to sign any type of “release” in connection with entry of a WLS order.

(f) The attending physician will promptly inform all personnel who are responsible for the patient's care, particularly the nursing staff, about the WLS decision, so that they understand its rationale and its implications
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(g) A WLS order should be reviewed routinely on rounds, when a change in clinical service or attending physician occurs and whenever there is a significant change in the patient’s condition.

(h) If the patient is being considered for major invasive procedures (such as operations) the indication for the procedure and the rationale behind the intervention and the patient’s wishes will be reviewed.

(i) The WLS order will stand unless rescinded either by the attending physician (verbal orders will be accepted) or at any time when a patient with decision making capacity or the surrogate make this request known to any health care provider responsible for the patient's care.

(j) Rescission of the WLS order will be documented as outlined in paragraph 8 f. above.

9. Administration

a. The WRAMC ECS is available to help resolve ethical issues pertaining to problems concerning medical treatment decisions. Any member of the medical center staff, the patient, the patient's surrogate decision-maker, or a member of the patient's family may request an Ethics consultation.

b. The HEC will be consulted when.

(1) There is a lack of concurrence between a clinician and the patient or surrogate decision-maker(s) concerning the propriety of WLS.

(2) The patient has no next-of-kin, a person named in a durable power of attorney for health care, or legal guardian, and WLS is indicated.

(3) There is a question concerning other ethical concerns pertaining to WLS.

(4) Unresolved ethical conflicts among clinicians that may potentially harm the patient.

c. If the attending physician considers a patient's WLS request unacceptable and is unable to carry out the patient's wishes, the physician may transfer patient responsibility to another physician. If any other member of the health care team finds caring for such a patient morally or ethically objectionable, a discussion should be held with his/her supervisor who will assign the patient to a different caregiver.

d. The ECS and Medical Center Chain of Command are available to assist in resolving issues concerning the transfer of the patient to different health care providers.

The proponent agency for this regulation is the Walter Reed Army Medical Center Ethics Committee. Users are invited to send suggestions and comments on a DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, Walter Reed Army Medical Center, ATTN: MCHL-SCC, Washington, DC 20307-5001

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